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☞ Parent/Descendent Exam and Printsets

A major enhancement to this version is a single combined report for a set of related procedures. This is a "printset" mechanism for entering a single report for all descendent cases registered from a parent order (See Procedure Enter/Edit for more information on parent procedures). For more detailed information see Parent/Descendent Exams and Printsets. The ability to create a separate report for each procedure ordered under a single parent procedure still exists.

☞ Radiopharmaceuticals

Another important addition with this version is the ability to enter and edit information specific to radiopharmaceuticals for Nuclear Medicine. A new menu, Nuclear Medicine Setup Menu under the Utility Files Maintenance Menu, allows the site to define parameters for radiopharmaceuticals concerning lot number, route and site of administration, and source/vendor. The addition of radiopharmaceutical fields has a major effect on case and status edits for Nuclear Medicine and Cardiology Studies Imaging Types. For more complete information, refer to the chapter Case Edits and Status Tracking.

Implementation Check List

Update from V. 4.5 to V. 5.0

This implementation checklist assumes that you have fully implemented version 4.5 and now want to review for implementation the new functionality available in this version.

Before IRM loads this version into production:

a. Review the Release Notes to acquaint yourself with any changes that were made to this version of the software and update the users to those changes.

b. Review all new items in this manual (those designated by ☞) and read the chapters on Single Reports for Parent/Descendent Exams and Printsets and Case Edits and Status Tracking. Also, Procedure Enter/Edit in this manual and Report Entry/Edit and Diagnostic Code and Interpreter Edit by Case No. in the user manual are affected by printsets.

c. Radiology/Nuclear Medicine accesses the Pharmacy Drug file #50 for radiopharmaceuticals and their associated VA Classifications; therefore, the Drug file must contain all the radiopharmaceuticals used at your site. Provide the Pharmacy ADPAC with a list of the radiopharmaceuticals and work with the ADPAC to enter them into the Drug file. When entering Radiopharmaceuticals into the Drug file, it is recommended to enter the Nuclide then the Pharmaceutical as the Drug Name and also a synonym to make it easier for Radiopharmaceuticals to be retrieved. (See Example Radiopharmaceutical Drug Classifications under the chapter Worksheets.)

   The Radiopharmaceuticals should be assigned one of the following VA Classifications under Diagnostic Agents:

   DX200 Radiopharmaceuticals, Diagnostic
   DX201 Imaging Agents (in vivo), Radiopharmaceuticals
   DX202 Non-Imaging Agents Radiopharmaceuticals

d. If a status's Order is removed through the Examination Status Entry/Edit option but the Appear on Status Tracking field is set to YES, exams in that status will, after the installation of version 5.0, be available for edit in Status Tracking of Exams. The inactivated status will be processed after the active statuses. The purpose of this feature is to allow processing of exams to complete if they are in an inactive status and the case edit options do not prompt for the required fields to allow data entry to complete the cases. **If your site has a large volume of historic cases that fall into this category, you may want to make sure the Appear on Status Tracking field is set to NO prior to the installation of this version**.

e. Print the Active Procedure List (Short) to get a list of Nuclear Medicine procedures that can be used to fill out your worksheets for procedure set-up.

f. It will be necessary to train the technologists and transcriptionists in handling case and report entry/edits for printsets. This should be done in your training account prior to installing live.

   The technologists must be made aware of the following:

   1) If an exam is added through the Add Exam to Last Visit option, and the last visit was a printset/parent, the added exam becomes part of the printset. The report will be a single one even if the added exam is quite different from the substance of the parent.

   2) If there are two parent requests of the same Imaging Type, do not use the Add Exam to Last Visit option to add the procedures of the second parent to the first. Doing this will create a single report for all procedures from both parents, and the second request will never be completed because all descendants will apply to completing the first request.

While you do the setup required after installation, Imaging Service users must be off the system. You should prepare as much as possible to minimize the downtime for Imaging Service users.

The following is a listing and discussion of all the new functionality that you may want to edit in setting up this version. It is strongly suggested that you review the following checklist and complete any worksheets **prior to the actual setup**. Then use the completed checklist and worksheets during the setup.

❑ 1. Division Parameter Set-up.

a. AUTO E-MAIL TO REQ. PHYS? -If you want to automatically send Radiology/Nuclear Medicine findings when they are verified to the requesting physician via e-mail, you need to enter YES in this field.

Division	**E-Mail Findings**

b. RPHARM DOSE WARNING MESSAGE - If you want to display a message other than the default message

```
This dose requires a written and signed directive by a physician.
```

to the user when the radiopharmaceutical dose falls outside the range of the "Low Adult Dose" and the "High Adult Dose", enter the message here. These fields reside in the Default Radiopharmaceuticals multiple in the Rad/Nuc Med Procedures file. Use the Procedure Enter/Edit option to adjust these values.

Message: _____
_____
_____

❑ 2. Location Parameter Set-up.

a. ALLOW 'RELEASED/NOT VERIFIED' - If you want to be able to display unverified reports to users outside the Imaging service, this Imaging Location parameter should be set to YES. This field was moved from the Division parameters. If as a Division parameter it contained a YES, then all the Imaging Locations for that Division will contain a YES in this field as a default after this version is installed. Otherwise, the default will be no.

Location	Send Alert	Allow Released/ Unverified

b. STAT REQUEST ALERT RECIPIENTS - List any Radiology/Nuclear Medicine personnel that should receive an alert whenever a STAT request is submitted to the Imaging Location. Bypass this step if you don't want alerts sent.

Note: To receive a STAT request alert, recipients must have a Radiology/Nuclear Medicine personnel classification. **To use this feature, the Division parameter, "Ask Imaging Location" must be set to YES, and CPRS (OE/RR V. 3.0 or higher) must be installed.**

Locations:	Recipients:

c. URGENT REQUEST ALERTS? - If you want to send alerts to selected personnel whenever there is a STAT request, enter YES in this field. Personnel designated to receive STAT request alerts will also receive URGENT alerts. **Note: To use this feature, the Division parameter**

"**Ask Imaging Location**" **must be set to YES, and CPRS (OE/RR V. 3) or higher must be installed.**

❑ 3. Diagnostic Code Enter/Edit.

INACTIVE - Print out a list of your diagnostic codes using the option Diagnostic Code List. If you want to inactivate any of the codes, so they do not appear as selections to the users, highlight them and refer to that list when doing this step of the setup.

❑ 4. Examination Status Entry/Edit.

Editing this option takes a great deal of up front preparation. Make sure you read the information in the chapters Examination Status Entry/Edit and Case Edits and Status Tracking. Use the worksheet (See chapter Worksheets) when defining your changes.

A new Imaging Type, Mammography, was exported with this version. If you intend to activate Mammography as an Imaging Type, then be sure to include it when defining your changes to status tracking.

Note: This installation will **turn on** the "Ask Radiopharmaceuticals and Dosages" parameter for all nuclear medicine and cardiology studies procedures. All other new parameters will be off. In order for nuclear medicine technologists to accurately enter radiopharmaceuticals, all radiopharmaceuticals used at your site must be entered into the Pharmacy Drug file.

The new fields to edit for all Imaging Types are as follows:

a. GENERATE EXAMINED HL7 MESSAGE
b. ASK MEDICATIONS & DOSAGES
c. ASK MEDICATION ADMIN DT/TIME & PERSON

There are a number of new fields for Nuclear Medicine. If your facility wants to record data in most or all of the new radiopharmaceutical data fields, you will have to use Status Tracking to edit cases. Only through Status Tracking will you be able to control which prompts are asked at which statuses. In order to provide simplicity and avoid extra undesirable prompts at facilities who want to enter a minimum set of radiopharmaceutical data, the case editing options (Case No. Exam Edit and Edit Exam by Patient) do not

prompt for all the new Nuclear Medicine fields. Instead, only the **radiopharmaceutical, dose administered, date/time of dose administration,** and **person who administered dose** will be consistently asked for nuclear medicine or cardiology studies cases. However, if data has already been entered via Status Tracking in other nuclear medicine related fields, the case edits will prompt for those fields to allow correction of erroneous radiopharmaceutical data already entered. In addition, if the procedure parameter so specifies, the case edits will prompt for radiopharmaceutical dose prescribed, prescribing physician, and witness to dose administration. The new fields to edit for Nuclear Medicine and Cardiology Studies Imaging Types are as follows:

a. RADIOPHARMS & DOSAGES REQUIRED
b. ACTIVITY DRAWN REQUIRED (RADIOPHARM)
c. DRAWN DT/TIME AND PERSON REQUIRED (RADIOPHARM)
d. ADMIN DT/TIME/PERSON REQUIRED (RADIOPHARM)
e. ROUTE/SITE REQUIRED (RADIOPHARM ADMINISTERED)
f. LOT NO. REQUIRED (RADIOPHARM)
g. VOLUME/FORM REQUIRED (RADIOPHARM)
h. ASK RADIOPHARMACEUTICALS AND DOSAGES
i. ASK ACTIVITY DRAWN (RADIOPHARMACEUTICAL)
j. ASK DRAWN DT/TIME & PERSON (RADIOPHARMACEUTICAL)
k. ASK ADMIN DT/TIME & PERSON (RADIOPHARMACEUTICAL)
l. ASK ROUTE/SITE OF ADMIN (RADIOPHARM)
m. ASK LOT NO. (RADIOPHARM)
n. ASK VOLUME/FORM (RADIOPHARM)
o. PRINT DOSAGE TICKET WHEN EXAM REACHES THIS STATUS
   Note: Printing of the dosage ticket requires that a valid print device assigned to the location (see IRM Menu, Device Specifications for Imaging Locations option, Dosage Ticket Printer prompt) and YES answered for the Radiopharms/Dosages Required field at the status you are editing (or lower).

❑ 5. Examination Status Entry/Edit

Even if you do not make changes to the exam status parameters, select the option for each Imaging Type. This will trigger the Data Inconsistency Report and identify all problems. You can up-arrow at the Select an Examination Status prompt as shown here:

```
Select an Imaging Type: NUCLEAR MEDICINE

Select an Examination Status: ^

 _________ Checking order numbers used for status progression _________
```

```
            within : NUCLEAR MEDICINE

      Required order numbers are in place.

                  Data Inconsistency Report For Exam Statuses

DEVICE: HOME// (Enter a printer name)
```

❑ 6. Label/Header/Footer Formatter. There are a number of new fields available that could be added to labels, headers or footers:

Long Case Number Barcode
Resident Signature Name
Staff Signature Name
Verifying Signature Name
Verifying Signature Title
Patient Address Line 1
Patient Address Line 2
Patient Address Line 3

❑ 7. Nuclear Medicine Setup Menu contains four options. Routes and sites of administration of radiopharmaceuticals were exported with this version. Review the data in those files, using the print options Route of Administration List and Site of Administration List, before adding more entries. Worksheets for all four options are available in the chapter Worksheets. Add sites and vendors/sources before adding routes and lot numbers. Sites should be entered before routes so they will be selectable as valid sites for a route and lot numbers can be associated with vendors/sources. Also, routes and sites must be available for the next step, Procedure Enter/Edit. You may also want to request that IRM add the Lot Number Enter/Edit as a secondary menu option for the Nuclear Medicine technologists.

❑ 8. Procedure Enter/Edit. This is another complex setup that requires considerable up front preparation. If you plan to use the nuclear medicine features, you will need to enter radiopharmaceutical parameters on the appropriate procedures. Use the worksheet making as many copies as necessary. The new fields to edit for all Imaging Types are as follows:

a. SINGLE REPORT

b. PROMPT FOR MEDS
c. DEFAULT MEDICATION
d. EDUCATIONAL DESCRIPTION
e. DISPLAY EDUCATIONAL DESCRIPTION

Note: If you turn parents into printsets by answering YES to the "Single Report" prompt, the printset features will only take effect on cases registered **after** V. 5.0 is installed.

The new fields to edit for Nuclear Medicine and Cardiology Studies Procedures are as follows:

a. SUPPRESS RADIOPHARM PROMPT
b. PROMPT FOR RADIOPHARM RX
c. DEFAULT RADIOPHARMACEUTICAL
    LOW DOSE
    HIGH DOSE
    USUAL DOSE
    ROUTE
    FORM

If your site uses Parent procedures and you want a single report for all descendents, you can use the Print File Entries option to obtain a list of Parent procedures. You need not print the descendents as shown in this example. Or, you can use one of the existing procedure listing options to get complete data for all active procedures.

```
Select Supervisor Menu Option:  Print File Entries

OUTPUT FROM WHAT FILE: (file name)// RAD/NUC MED PROCEDURES
SORT BY: NAME// TYPE OF PROCEDURE
START WITH TYPE OF PROCEDURE: FIRST// P  PARENT
GO TO TYPE OF PROCEDURE: LAST// P  PARENT
  WITHIN TYPE OF PROCEDURE, SORT BY:
FIRST PRINT FIELD: NAME
THEN PRINT FIELD: DESCENDENTS      (multiple)
  THEN PRINT DESCENDENTS SUB-FIELD: .01  DESCENDENTS
  THEN PRINT DESCENDENTS SUB-FIELD: <RET>
THEN PRINT FIELD: <RET>

  ************************
Heading (S/C): RAD/NUC MED PROCEDURES LIST  Replace <RET>
START AT PAGE: 1// <RET>
DEVICE: (device name)
```

❑ 9. Reason Edit. If your site is running CPRS (OE/RR V. 3.0), you will want to review the Reason Edit chapter and decide what to do with the new field Nature of Order Activity.

❑ 10. If you activate the new Imaging Type Mammography, be sure to enter any modifiers you want for that Imaging type using the option Procedure Modifier Entry.

❑ 11. If you want Request Cancellations to print, give your IRM support staff a list showing which printer for each imaging location should be used to print them. They will enter these via their IRM menu using the Device Specifications for Imaging Location option.

❑ 12. This release is year 2000 compliant. The Date of Birth and Current Patient Location (which is date/time stamped) fields for labels, headers and footers are affected because the year is now printed as four digits instead of two. Retest any labels or report headers/footers that contain these fields to make sure they don't line wrap.

Virgin Installation (no previous version installed or implemented)

❑ 1. Before IRM loads this system into production, you should read this manual, read over the installation instructions listed here, and complete any related worksheets. The software should be installed in a Training environment first so you can familiarize yourself with the setup procedure and train users as much as possible before going live.

❑ 2. Before you begin the process of building your files, you should consult with your IRM Service to be sure you have access to the security keys (RA MGR, RA ALLOC and RA VERIFY) and have been assigned the Rad/Nuc Med Total System Menu.

❑ 3. Provide the Pharmacy ADPAC with a list of the radiopharmaceuticals and work with the ADPAC to enter them into the Drug file. See an example of Radiopharmaceutical entries in the Drug file under the chapter Worksheets. They should be assigned one of the following VA Classifications under Diagnostic Agents:

DX200 Radiopharmaceuticals, Diagnostic
DX201 Imaging Agents (in vivo), Radiopharmaceuticals
DX202 Non-Imaging Agents Radiopharmaceuticals

❑ 4. Edit parameters for each Division at your facility using the option, Division Parameter Set-up. (See chapter Worksheets)

❑ 5. Edit parameters for each Imaging Location by using the option Location Parameter Set-up. (See chapter Worksheets)

❑ 6. Use the option Examination Status Entry/Edit for each Imaging Type that you activate at your facility. Read about examination status tracking first, including the information in chapter Case Edits and Status Tracking, so that you understand the implications of activating an Imaging Type. You should have the exam status worksheets filled out ahead of time so that this part of the setup goes smoothly.

❑ 7. Review the rest of the options in the System Definition Menu and the Utility Files Maintenance Menu and make any changes that are appropriate for your site. Look for worksheets at the back of this manual.

❑ 8. Use the print options in the System Definition Menu, Rad/Nuc Med Personnel Menu, and the Maintenance Files Print Menu to obtain dated hard copies of the data for your records.

❑ 9. Determine the menus and/or options you need to assign to each of your users. There are a number of work related menus (such as clerk, fileroom, radiologist, ward, technologist, etc.) exported with this package. See the technical manual for more information. Give the list to IRM. You may want to review the Mailman bulletins provided by the Radiology/Nuclear Medicine software with IRM so mail groups with the appropriate members can be set up.

☞❑ 10. **This item is extremely important and should be done as soon as the above steps are complete. No user will be able to sign-on to the Radiology/Nuclear Medicine package unless s/he is assigned at least one Imaging Location.** Use the option Classification Enter/Edit in the Rad/Nuc Med Personnel Menu **now** and give each user access to whatever Imaging Locations they work with. It may be desirable to assign the RA ALLOC key to transcriptionists if they need to enter reports for all Imaging Locations.

❑ 11. Continue training your users.

changes. Request status changes pertain solely to the physician's order and whether it is in one of the following statuses: discontinued, complete, hold, pending, active, scheduled, unreleased. Request status changes can be used to find the status of an order at any given time in the past.

If you choose to bypass this prompt, the system default is NO and it will not keep track of this information. It will not automatically add the dates and times of status changes or the users requesting the change in status.

3) CLINICAL HISTORY MESSAGE - This is an **optional**, free text message, 5-70 characters in length, that is displayed just prior to the prompt for the clinical history field. This is often used to remind the person entering the request that specific information is needed in the patient's clinical history.

If you bypass this field, no message will appear prior to the user seeing the prompt for the clinical history.

Exam Entry/Edit Parameters

4) DETAILED PROCEDURE REQUIRED - If set to YES, entry of a Parent, Series or Detailed procedure type, will be required. If set to NO, procedures with the procedure type Broad will be accepted during order entry as a valid entry. This parameter in the division of the requesting location is used to determine if a broad procedure can be ordered. At the time the procedure is registered, broad types won't be allowed if either the division of the imaging location or the division of the requesting location requires a detailed procedure. If no division is entered on the requesting (or imaging) location in the Hospital Location file #44, the primary division will be used. Depending on parameters in the Examination Status file, you can require that the procedure be changed to either a Series or Detailed procedure by the radiology or nuclear medicine staff in order for the examination to acquire a given status. Again think about those entering orders; will they be able to discriminate between the more specific Detailed and Series type procedure, or will they be more comfortable selecting a general procedure name from the Broad types?

If you choose to bypass this prompt, the system default is NO and users will be able to request Broad type procedures.

5) ASK 'CAMERA/EQUIP/RM' - Setting this parameter to YES indicates that the question "Primary Camera/Equip/Rm" will be asked when the user is entering data about the examination in status tracking. If you want to

track camera, equipment or room use for each procedure, answer YES to this prompt, keeping in mind that the user may still bypass the question if s/he chooses to do so. (The Examination status parameters can be set to **require** this data before an exam can progress to a Complete (or other) status.)

If you accept the default of NO, the user will not see the Primary Camera/Equip/Rm prompt.

6) AUTO USER CODE FILING - The access code entered at sign-on is used automatically for the activity logs if this parameter is set to YES. If NO, the user(s) will be asked to enter access codes during various processes. This feature was used in older versions to minimize security risks of unattended logged-in terminals and multiple users sharing one terminal. It should not be necessary at most sites now, and should therefore be set to YES.

7) TRACK EXAM STATUS CHANGES - Setting this parameter to YES results in the recording of the dates/times of examination status changes. These statuses pertain to the exam, not the request. Statuses are defined by the site using the option Examination Status Entry/Edit. Examples of statuses that might be defined are as follows: Called for Exam, Cancelled, Complete, Examined, Transcribed, Waiting for Exam, etc.

If you choose to bypass this field, the system will **not** automatically record the dates and times of status changes and who made the changes.

8) ASK EXAM STATUS TIME - If the Track Exam Status Changes parameter is set to YES, then this parameter will appear. Setting this parameter to YES indicates that the user should be asked the time of the status change. The Date/Time is added to the Status Change Dt/Time subfile and to the Activity Log.

If set to NO or bypassed, the system automatically uses the current date and time and the prompt for time will not appear. This data is added only to the Activity Log.

9) TIME LIMIT FOR FUTURE EXAMS - This parameter sets a specific number of hours in the future during which a patient can be registered for an exam. If this prompt is bypassed, the user will not be able to register a patient for a future date or time. The number of hours cannot exceed 168 (one week). Generally, registering a patient is done when the patient arrives at the Imaging Location. Registering a patient is not the same as scheduling a patient for a procedure, which takes any future date you want.

Note: Registering patients in advance opens the possibility for exam updating before the exam really takes place. This can cause failure of workload crediting. Registration more than 24 hours in the future is not recommended.

Films Reporting Parameters

10) ALLOW STANDARD REPORTS - Transcriptionists will be able to select a standard report when using the Report Entry/Edit option if this parameter is set to YES. There is an option, Standard Reports Entry/Edit, which can be used to build a standard report with a report text that is often used. An example of a standard/routine exam might be, Normal Chest with the text reading "Chest exam is within normal limits". If there are a number of such exams reported, allowing the transcriptionists this ability saves time. These standard reports are discussed in a later chapter.

11) ALLOW BATCHING OF REPORTS - If set to YES, the transcriptionist can group reports, generally by physician name, for easy, organized access or printing. If changes must be made, the transcriptionist can look for the report within a batch rather than by keeping track of record numbers and patient names. It provides a time-saving way to organize work.

12) ALLOW COPYING OF REPORTS - Contents of one report can be copied to another if this parameter is set to YES. If a patient has had more than one test and the report text and impression of one report are needed for another, this handy ability helps save time. It places the entire report text and impression text of the selected report into the one you are editing. The text can then be further edited. The Clinical History will be moved from the patient's current exam record to the report record, not from the copied report.

13) IMPRESSION REQUIRED ON REPORTS - Set this parameter to YES if the impression is required on a report in order for it to become verified and for the exam to progress to a status of Complete. (Also, see Examination Status parameter instructions for setting up at least the Complete status to require Impression if this parameter is set to YES.)
Note: It is highly recommended that this parameter be set to YES. When reports are purged from the system, the clinical history and report text are deleted. Only the impression is retained on line.

14) ALLOW VERIFYING BY RESIDENTS - This parameter can be set to YES to allow interpreting residents to verify their own reports while doing On-line Verifying of Reports. Further, if this parameter is set to YES and the resident's **individual** parameter, Allow Verifying of Others (in the New

Person file), is **also** set to YES, the resident will be allowed to verify other interpreting physicians' reports in addition to their own.

It is recommended that residents NOT be allowed to verify reports because of the legal implications of report verification.

15) ALLOW RPTS ON CANCELLED CASES? - If this field is set to YES, any user can enter a report on a cancelled exam.

If this parameter is set to NO, only users who own the RA MGR key can edit or enter a report on a Cancelled case.

16) WARNING ON RPTS NOT YET VERIF? - If this field is set to YES, results reports in all statuses except "Verified" will contain the status surrounded by asterisks under the body of the printed report. This can be useful in making sure that unverified report copies are not placed in patient charts or mistakenly interpreted as final results. (This is not a new feature. Only the name was changed.)

17) AUTO E-MAIL TO REQ. PHYS? - If this field is set to YES, the system will automatically send the Radiology/Nuclear Medicine findings report to the Requesting Physician via e-mail at the time it is verified. If this field is left blank, verified reports will not be e-mailed to the requesting physician.

When a report is verified, the Auto E-Mail to Req. Phys. Field of the division for the requesting location is used to determine whether to send results to the requesting physician. If the requesting location is not assigned to a division in the Hospital Location file #44, the primary division will be used. **Note: If the requesting location is assigned to a division in the Hospital Location file #44, make sure that division is also defined in the Rad/Nuc Med Division file #79.**

Miscellaneous Division Parameters

18) PRINT FLASH CARD FOR EACH EXAM - To have **one** flash card automatically printed with each registration of a **case** for all Imaging Locations, set this parameter to YES. To allow the printing of more than one flash card, set this parameter to NO and use the Location Parameter Set-up option to enter the number you want printed for each location.

19) PRINT JACKET LBLS W/EACH VISIT - Indicate to the system that a jacket label be printed with each visit (may include many cases/exams) by

☞Cost of Procedure Enter/Edit [RA PROCOSTEDIT]

This function allows you to apply a cost to procedures. Unit cost and Total cost appear on the Procedure/CPT Statistics Report [RA CPTSTATS].

You are asked for an imaging type, the procedure you want to edit, and the cost. Only procedures matching the selected imaging type(s) can have their cost edited. Select procedures by entering either the CPT code for the procedure or the procedure name.

```
Cost of Procedure Enter/Edit

Select Imaging Type: All// <ret>

Another one (Select/De-Select): <ret>

Select RAD/NUC MED PROCEDURES NAME: 71020          CHEST X-RAY  CHEST 2 VIEWS
PA&LAT     (RAD  Detailed) CPT:71020
COST OF PROCEDURE: 99.98
```

Procedure Enter/Edit [RA PROCEDURE]

This function allows you to enter new procedures into the system and to edit existing procedures. Entries in this file are used as the allowable selections for users at any Procedure prompt. This prompt appears as part of the Request an Exam, Register an Exam, Add Exam to Last Visit, Case No. Exam Edit, and the Exam Status Tracking options.

1) RAD/NUC MED PROCEDURES NAME - You can only edit the name of the procedure if the procedure was added by your site; if the procedure was distributed by the package, editing the name field is not allowed. Entries are related to Imaging Types. If the same procedure is done by two different locations of differing Imaging Types then you need to enter them with slightly different names but with the same CPT and AMIS codes:

   US - Carotid doppler
   VAS - Carotid doppler

2) TYPE OF IMAGING - This field is used to associate a particular Imaging Type to a procedure. Each procedure can only be associated with one Imaging Type. You may enter a new procedure with a slightly different name to make it show up for a second Imaging Type.

   Example: You want Carotid Doppler for Ultrasound and for Vascular Lab. One procedure can be called Carotid Doppler and assigned to the Ultrasound Imaging Type and the other VAS - Carotid Doppler with the Vascular Lab Imaging Type.

If you have activated a new Imaging Type and are changing the Imaging Type of procedures to match the new Imaging Type, you will also have to deactivate these procedures from the Common Procedure list (if they are common procedures). They can later be put on a separate new common procedure list under the new Imaging Type. Refer to Common Procedure Enter/Edit for more information.

3) TYPE OF PROCEDURE - There are four types of procedures:

   Detailed - Procedure is associated with an AMIS code and must have a CPT (Current Procedural Terminology) code assigned to it.

   Series - Procedure is associated with more than one AMIS code and must have a CPT code assigned to it. It is recommended that the Type of Procedure field be set to Series for all procedures with more than

one AMIS code. In addition to being reported under each AMIS code, the procedures with multiple AMIS codes are also tallied in the "Series of AMIS Codes" line item of the AMIS Report. Setting these procedures as a Series type serves as a reminder to users. The AMIS Report counts each Series procedure the same as the Detailed procedure in the body of the report, but an additional line tallies the Series procedures by themselves. The Bilateral, Operating Room, and Portable modifiers are not allowed for Series procedures as that would cause the AMIS Report to be incorrect.

Broad - Procedure is mainly used by the receptionist, clerk, or ordering clinician when scheduling a patient for an exam. It is used when s/he is not exactly sure which Detailed or Series procedure will be performed. However, before the exam can be considered Complete, the procedure should be changed to a Detailed or Series in order to insure adequate workload credit to your facility. Broad procedures are not associated with a CPT or AMIS codes. These prompts will not be seen if the user selects Broad as the procedure type. If no CPT code is entered for a Detailed or Series procedure, the procedure type is automatically changed to Broad.

If the Division parameter requiring a Detailed or Series procedure upon initial exam registration is set to YES, then the ordering party will not be able to select a Broad procedure.

Parent - Procedure is used for ordering purposes only. It must have descendents (other procedures of Detailed or Series type) that are actually registered. Parent procedures are used to simplify the ordering process when a group of related procedures must be done. (See Parent/Descendent Exam and Printsets.) Similar to Broad procedures, they act as temporary placeholders. When a parent order is requested, the system automatically finds all the descendants and the parent itself is never actually registered.

When creating a Parent procedure, make the parent name slightly different than any of its descendents so the system will accept it as a new procedure. **Remember, when creating a Parent, no CPT code is entered therefore, it will not be registered**. All descendents must be either Detailed or Series Type with a CPT code.

Example:

Parent:	Arthrogram of the Shoulder (or Arthrogram - Shoulder)
Descendents:	73040
	23350

4) SINGLE REPORT - This is a new field that only appears when you define a procedure as a Parent procedure. If this field is left unanswered, then the reporting of the procedure's descendents will be put into separate reports, as in the previous version. If this field is answered YES, then the reporting of the procedure's descendents will be combined into one report, where the case records for these descendents will have the same data for report text, impression, pre-verifier, verifier, staff (primary and secondary), residents (primary and secondary), diagnoses, and all other report-related fields.

5) HEALTH SUMMARY WITH REQUEST - This field points to the Health Summary Type file. When a procedure is requested, this field is checked for an associated Health Summary Type and, if one exists, it is printed along with the request. You can select an appropriate Health Summary Type here. If necessary, you may need to check with your clinical coordinator for help in setting up useful health summary formats.

6) SYNONYM - One or more synonyms may be associated with a procedure. At any Procedure prompt, a synonym can be entered to select a procedure if you have predefined the synonym here.

7) PROMPT FOR MEDS - This is a new field. It only appears for procedures that are Detailed or Series. If this field is set to YES, case edits will prompt for medications administered for this procedure. To make Status Tracking prompt for medications administered, this field must be set to YES **and** the Examination Status parameter "Ask Medications & Dosages" must be set to YES for one or more statuses of the procedure's Imaging Type.

8) DEFAULT MEDICATION - This is a new field. It only appears for procedures that are Detailed or Series. Use this field to enter any medications when they are usually used for the procedure. Radiopharmaceuticals may not be entered in this field. Medications, if defined here, are entered automatically into the patient exam record by the system during registration.

Supervisor Menu ...

Maintenance Files Print Menu ...

Complication Type List
Diagnostic Code List
Examination Status List
Film Sizes List
Label/Header/Footer Format List
Major AMIS Code List
Modifier List
Nuclear Medicine List Menu...
Procedure File Listings...
Report Distribution Lists
Sharing Agreement/Contract List
Standard Reports Print

Overview:

This menu corresponds to the Utility Files Maintenance Menu. Each option allows you to print out a dated, hard copy of the data from the related file.

Complication Type List [RA COMPRINT]

This option provides a list of the complications from the Complication Types file #78.1 and whether or not each is considered a Contrast Medium Reaction.

For more information on complication types, refer to the Index and the chapter on Complication Type Entry/Edit.

Prompt/**User Response**	Discussion
`Complication Type List`	
`DEVICE: (Printer Name)`	Enter the name of a printer or press the <RET> key to display the output on your screen.

```
Complication Types                          SEP 30,1996  08:52    PAGE 1
                                 CONTRAST
                                 MEDIUM
COMPLICATION                     REACTION?
-------------------------------------------------------------------------
-

CONTRAST REACTION                YES
NAUSEA AND VOMITING              NO
NO COMPLICATION                  NO
PREGNANCY                        NO
SEVERE MORBIDITY                 NO
```

Diagnostic Code List
[RA DIAGP]

This option lists the contents of the Diagnostic Codes file #78.3.

For more information diagnostic codes, refer to the Index and the chapter on Diagnostic Code Enter/Edit.

Prompt/**User Response**	Discussion
`Diagnostic Code List`	
`DEVICE: (Printer Name)`	Enter the name of a printer or press the <RET> key to display the output on your screen. See the next page for an example of a list.

```
Diagnostic Codes                                SEP 30,1996  08:53    PAGE 1
                                                              PRINT
                                                              ON           GENERATE
                                                              ABNORMAL     ABNORMAL
NUMBER   DIAGNOSTIC CODE                                     REPORT       ALERT?
-------------------------------------------------------------------------------
   1     NORMAL                                               NO
There were no problems for this exam!
-------------------------------------------------------------------------------
   2     MINOR ABNORMALITY                                    NO
There was a slight abnormality in this exam!
-------------------------------------------------------------------------------
   3     MAJOR ABNORMALITY, NO ATTN. NEEDED                   NO
There was a major problem, but no attention was needed!
-------------------------------------------------------------------------------
   4     ABNORMALITY, ATTN. NEEDED                            YES          YES
There was a major problem, and attention is necessary!
-------------------------------------------------------------------------------
   5     MAJOR ABNORMALITY, PHYSICIAN AWARE                   NO
There is a major problem, and the doctor is aware of it!
-------------------------------------------------------------------------------
   6     UNDICTATED FILMS NOT RETURNED, 3 DAYS                NO
-------------------------------------------------------------------------------
   7     UNSATISFACTORY/INCOMPLETE EXAM                       YES
This exam was either unsatisfactory or incomplete!
-------------------------------------------------------------------------------
   8     POSSIBLE MALIGNANCY, FOLLOW-UP NEEDED                YES
A possible malignancy was noted.  Follow-up action should be taken.
-------------------------------------------------------------------------------
   9     POSSIBLE MALIGNANCY, FOLLOW-UP CRITICAL
Follow-up must be done, and documented
-------------------------------------------------------------------------------
  10     OVEREXPOSURE, MECH ERROR                             YES          NO
OVEREXPOSURE DUE TO A MECHANICAL ERROR
-------------------------------------------------------------------------------
```

Note: A blank in the "Print on Abnormal Report" column or the "Generate Abnormal Alert?" column is the same a "NO".

Examination Status List
[RA EXAMSTATUSP]

This option lists the contents of the Examination Status file #72. It lists all contents of the Examination Status file whether or not the Imaging Types and statuses are activated. Our example shows only one of the Imaging Types that has been activated.

For more information on exam statuses, refer to the index and the chapter on Examination Status Entry/Edit.

Prompt/**User Response**	Discussion
`Examination Status List`	
`Select Imaging Type: **NUC**LEAR MEDICINE`	This report now allows printing by selected Imaging Types.
`Another one (Select/De-Select): **<RET>**`	Enter the name of a printer or press the <RET> key to display the output on your screen.
`Select Device: (Printer Name)`	See the next three pages for an example of the output.

```
                          Examination Statuses                 Page: 1
                      Run Date: Jan 27, 1997 8:45:12 am
--------------------------------------------------------------------------------
          Type Of Imaging: NUCLEAR MEDICINE

Status: ***CANCELLED***                              Order: 0
Default Next Status:                                 User Key Needed:
Generate Examined HL7 Message:
Generate Exam Alert:                                 Allow Cancelling?: YES
Appear On Status Tracking?: NO                       Print Dosage Ticket: NO

ASK ON STATUS TRACKING:               REQUIRED FOR CHANGE TO THIS STATUS:
----------------------                ----------------------------------

         WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
         ------------------------------------------------------
              AMIS


Status: ***WAITING FOR EXAM***                       Order: 1
Default Next Status: EXAMINED                        User Key Needed:
Generate Examined HL7 Message:
Generate Exam Alert: NO                              Allow Cancelling?: YES
Appear On Status Tracking?: YES                      Print Dosage Ticket: NO

ASK ON STATUS TRACKING:               REQUIRED FOR CHANGE TO THIS STATUS:
----------------------                ----------------------------------

         WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
         ------------------------------------------------------
              CLINIC
              PTF BEDSECTION
              SERVICE
              SHARING/CONTRACT
              WARD
              FILM USAGE
              TECHNOLOGIST
              AMIS
              DETAILED PROCEDURE
              CAMERA/EQUIP/RM
              PHYSICIAN
              RESIDENT
              STAFF
              DELINQUENT STATUS
```

```
                        Examination Statuses                 Page: 2
                     Run Date: Jan 27, 1997 8:45:12 am
--------------------------------------------------------------------------------

Status: ***EXAMINED***                                 Order: 2
Default Next Status: TRANSCRIBED                       User Key Needed:
Generate Examined HL7 Message: YES
Generate Exam Alert: NO                                Allow Cancelling?: NO
Appear On Status Tracking?: YES                        Print Dosage Ticket: YES

ASK ON STATUS TRACKING:                REQUIRED FOR CHANGE TO THIS STATUS:
-----------------------                ----------------------------------
    TECHNOLOGIST                           TECHNOLOGIST
    PROCEDURE                              DETAILED PROCEDURE
    FILM DATA                              FILM ENTRY
    CAMERA/EQUIP/RM                        CAMERA/EQUIP/RM
    MEDICATIONS & DOSAGES                  RADIOPHARMS/DOSAGES
    MED ADM DT/TIME/PERSON
    RADIOPHARMS AND DOSAGES
    ADM DT/TIME/PERSON
    LOT NO.

         WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
         -------------------------------------------------------
              CLINIC
              PTF BEDSECTION
              SERVICE
              SHARING/CONTRACT
              WARD
              FILM USAGE
              TECHNOLOGIST
              AMIS
              DETAILED PROCEDURE
              CAMERA/EQUIP/RM
              PHYSICIAN
              RESIDENT
              STAFF
              DELINQUENT STATUS


Status: ***TRANSCRIBED***                              Order: 3
Default Next Status: COMPLETE                          User Key Needed:
Generate Examined HL7 Message:
Generate Exam Alert: YES                               Allow Cancelling?: NO
Appear On Status Tracking?: NO                         Print Dosage Ticket: NO

ASK ON STATUS TRACKING:                REQUIRED FOR CHANGE TO THIS STATUS:
-----------------------                ----------------------------------
    TECHNOLOGIST                           TECHNOLOGIST
    INTERPRETING PHYS                      REPORT ENTERED
    PROCEDURE                              IMPRESSION
    FILM DATA                              RESIDENT OR STAFF
    DIAGNOSTIC CODE                        DETAILED PROCEDURE
    CAMERA/EQUIP/RM                        FILM ENTRY
    MEDICATIONS & DOSAGES                  CAMERA/EQUIP/RM
```

```
                          Examination Statuses                 Page: 3
                       Run Date: Jan 27, 1997 8:45:12 am
--------------------------------------------------------------------------------

    MED ADM DT/TIME/PERSON                  RADIOPHARMS/DOSAGES
    RADIOPHARMS AND DOSAGES
    ACTIVITY DRAWN
    DRAWN DT/TIME/PERSON
    ADM DT/TIME/PERSON
    ROUTE/SITE OF ADM
    LOT NO.
    VOLUME/FORM

         WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
         ------------------------------------------------------
              CLINIC
              PTF BEDSECTION
              SERVICE
              SHARING/CONTRACT
              WARD
              FILM USAGE
              TECHNOLOGIST
              AMIS
              DETAILED PROCEDURE
              CAMERA/EQUIP/RM
              PHYSICIAN
              RESIDENT
              STAFF
              DELINQUENT STATUS


Status: ***COMPLETE***                              Order: 9
Default Next Status:                                User Key Needed:
Generate Examined HL7 Message:
Generate Exam Alert: NO                             Allow Cancelling?: NO
Appear On Status Tracking?: NO                      Print Dosage Ticket: NO

ASK ON STATUS TRACKING:                 REQUIRED FOR CHANGE TO THIS STATUS:
----------------------                  -----------------------------------
    TECHNOLOGIST                            TECHNOLOGIST
    INTERPRETING PHYS                       REPORT ENTERED
    PROCEDURE                               VERIFIED REPORT
    FILM DATA                               IMPRESSION
    DIAGNOSTIC CODE                         RESIDENT OR STAFF
    CAMERA/EQUIP/RM                         DETAILED PROCEDURE
    MEDICATIONS & DOSAGES                   FILM ENTRY
    MED ADM DT/TIME/PERSON                  CAMERA/EQUIP/RM
    RADIOPHARMS AND DOSAGES                 RADIOPHARMS/DOSAGES
    ACTIVITY DRAWN
    DRAWN DT/TIME/PERSON
    ADM DT/TIME/PERSON
    ROUTE/SITE OF ADM
    LOT NO.
    VOLUME/FORM
```

```
                        Examination Statuses                  Page: 4
                     Run Date: Jan 27, 1997 8:45:12 am
--------------------------------------------------------------------------------

         WORKLOAD REPORTS THAT USE THIS STATUS IN ITS COMPLETION:
         -------------------------------------------------------
              CLINIC
              PTF BEDSECTION
              SERVICE
              SHARING/CONTRACT
              WARD
              FILM USAGE
              TECHNOLOGIST
              AMIS
              DETAILED PROCEDURE
              CAMERA/EQUIP/RM
              PHYSICIAN
              RESIDENT
              STAFF
              DELINQUENT STATUS
```

Film Sizes List
[RA FILMP]

This option lists the contents of the Film Sizes file #78.4.

For more information on films, refer to the Index and the chapter on Film Type Entry/Edit.

Prompt/**User Response**	Discussion
`Film Sizes List`	
`DEVICE: (Printer Name)`	Enter the name of a printer or press the <RET> key to display the output on your screen.

```
Film Size Specifications                        SEP 30,1996  08:55    PAGE 1
                      F                    W
                      l                    a
                  C   u                    s
                  i   o                    t   Analogous
                  n   r                    e   Unwasted Film
Film              e   o  Inactivation Dt   d   Size
-------------------------------------------------------------------------------

10X12             N
11X14             N
14X17             N
2X12              N
2X4               N      JUL 5,1996
2X6               N
3X FILMS          N
CHROMATIC         N
CINE              Y
DENTAL            N
FLUORO ONLY       N
NO FILMS          N
W-10X12           N                       Y   10X12
W-11X14           N                       Y   11X14
W-14X17           N                       Y   14X17
W-2X12            N                       Y   2X12
W-2X4             N      JUL 5,1996       Y   2X4
W-2X6             N                       Y   2X6
W-3X FILMS        N                       Y   3X FILMS
W-CHROMATIC       N                       Y   CHROMATIC
W-CINE            Y                       Y   CINE
W-DENTAL          N                       Y   DENTAL
W-FLUORO ONLY     N                       Y   FLUORO ONLY
```

Label/Header/Footer Format List [RA FLASHFORMP]

This option prints the contents of the Lbl/Hdr/Ftr Formats file #78.2.

For more information on formats, refer to the Index and the chapter on Label/Header/Footer Formatter.

Prompt/**User Response**	Discussion
`Label/Header/Footer Format List`	
`DEVICE: (Printer Name)`	Enter the name of a printer or press the <RET> key to display the output on your screen.

```
Exam Label/Report Header/Report Footer/Flash Card Formats
                                                SEP 30,1996  08:55    PAGE 1
  FIELD                          ROW COL  TITLE
                                                  TEXT
------------------------------------------------------------------------------

        FORMAT NAME: ER FORMAT
  NAME OF PATIENT                  1   2  NAME     :
  SSN OF PATIENT                   1  40  SSN :
  DATE OF EXAM                     2   1  EXAM DATE:
  TECHNOLOGIST                     2  40  TECH:
  PROCEDURE                        3   1  PROCEDURE:
  FREE TEXT                        5   2              COMMENTS :
  VERIFYING RADIOLOGIST           10   2  INTERPRETER:
```

```
Exam Label/Report Header/Report Footer/Flash Card Formats
                                                SEP 30,1996  08:55    PAGE 2
  FIELD                          ROW COL  TITLE
                                                  TEXT
------------------------------------------------------------------------------

        FORMAT NAME: EXAM HEADER
  FREE TEXT                        1   1              EXAM REPORT
  NAME OF PATIENT                  1  15  PATIENT:
  CURRENT DATE/TIME                1  50  DATE:
  SSN OF PATIENT                   2   1  SSN:
  ATTENDING PHYSICIAN AT ORDER     2  40  Att at Order:

  REQUESTING PHYSICIAN             3   1  REQ PHYS:
  ATTENDING PHYSICIAN CURRENT      3  40  Att Current:

  REQUEST ENTERED DATE/TIME        4   1
  CURRENT PATIENT LOCATION         5   1
```

Major AMIS Code List
[RA MAJORAMISP]

This option lists the contents of the Rad/Nuc Med AMIS Codes file #71.1.

For more information on AMIS codes, refer to the Index and the chapter on Major AMIS Code Entry/Edit.

Prompt/**User Response**	Discussion
`Major AMIS Code List`	
`DEVICE: (Printer Name)`	Enter the name of a printer or press the <RET> key to display the output on your screen.

```
Major AMIS Codes                              SEP 30,1996  08:56    PAGE 1
MAJOR
 AMIS
 CODE  DESCRIPTION                                              WEIGHT
-------------------------------------------------------------------------------

  1    SKULL,INC.SINUS,MASTOID,JAW,ETC                            3
  2    CHEST-SINGLE VIEW                                          1
  3    CHEST MULTIPLE VIEW                                        2
  4    CARDIAC SERIES                                             3
  5    ABDOMEN-KUB                                                2
  6    OBSTRUCTIVE SERIES                                         3
  7    SKELETAL-SPINE & SACROILIAC                                3
  8    SKELETAL-BONE & JOINTS                                     2
  9    GASTROINTESTINAL                                           6
 10    GENITOURINARY                                              6
 11    CHOLECYSTOGRAM,ORAL                                        5
 12    CHOLANGIOGRAM                                             10
 13    LAMINOGRAM                                                 5
 14    BRONCHOGRAM                                                5
 15    DIGITAL SUBTRACTION ANGIOGRAPHY                           15
 16    ANGIOGRAM,CATH- CEREBRAL                                  15
 17    ANGIOGRAM,CATH- VISCERAL                                  20
 18    ANGIOGRAM,CATH- PERIPHERAL                                10
 19    VENOGRAM                                                  15
 20    MYELOGRAM                                                 10
 21    COMPUTED TOMOGRAPHY                                        8
 22    INTERVENTIONAL RADIOGRAPHY                                20
 23    ULTRASOUND,ECHOENCEPHALOGRAM                               7
 24    OTHER                                                      5
 25    EXAMS IN OPER.SUITE AT SURGERY                             1
 26    PORTABLE (BEDSIDE) EXAMINATIONS                            1
 27    NUCLEAR MEDICINE                                           1
```

Modifier List
[RA MODIFIERP]

This option lists the contents of the Procedure Modifiers file #71.2.

For more information on modifiers, refer to the Index and the chapter on Procedure Modifier Entry.

Prompt/**User Response**	Discussion
`Modifier List`	
`DEVICE: (Printer Name)`	Enter the name of a printer or press the <RET> key to display the output on your screen.

```
Procedure Modifiers                          NOV 18,1996  13:52    PAGE 1
                                AMIS CREDIT
NAME                            INDICATOR
------------------------------------------------------------------------------


        TYPE OF IMAGING: CARDIOLOGY STUDIES (NUC MED)
RIGHT

        TYPE OF IMAGING: CT SCAN
RIGHT

        TYPE OF IMAGING: GENERAL RADIOLOGY
BILATERAL EXAM                  BILATERAL
PORTABLE EXAM                   PORTABLE
OPERATING ROOM EXAM             OPERATING ROOM
LEFT
RIGHT
TEST                            PORTABLE
TEST BILATERAL                  BILATERAL
TEST OR                         OPERATING ROOM
NEW ONE                         OPERATING ROOM
OBLIQUE
```

Series of Procedures List
[RA PROCSERIES]

This list is the same as the Active Procedure List (Long) except it contains only Series procedures.

Prompt/**User Response**	Discussion
`Series of Procedures List`	
`Select Imaging Type: All// GENERAL RADIOLOGY`	This report now allows printing by selected Imaging Types.
`Another one (Select/De-Select): <RET>`	
`This report requires a 132 column output device.` `DEVICE: (Printer Name or "Q")`	Enter the name of a printer that prints 132 columns. If you enter "Q" instead of a printer name, you will also see prompts for a device and a time to print.

```
Radiology/Nuclear Medicine Procedures (Series Only)                              SEP 30,1994 10:54  PAGE 1
CPT                                                                                                   CT
CODE     PROCEDURE                                    AMIS CODE                MULTIPLIER   BILATERAL  HEAD/BODY
-------------------------------------------------------------------------------------------------------------------
76062    BONE SURV COMP (INCL APPENDIC     1 -SKULL,INC.SINUS,MASTOID,JAW,ET    1

      Type of Procedure          :     SERIES
      Required Flash Card Printer:
      Required Flash Card Format :
      Staff Review of Reports Req:
      Rad Approval of Request Req:
      Type of Imaging            :     GENERAL RADIOLOGY
      Descendents                :
      Procedure Message          :
-------------------------------------------------------------------------------------------------------------------
76061    BONE SURV LMTD (E.G. METASTATI    1 -SKULL,INC.SINUS,MASTOID,JAW,ET    1

      Type of Procedure          :     SERIES
      Required Flash Card Printer:
      Required Flash Card Format :
      Staff Review of Reports Req:
      Rad Approval of Request Req:
      Type of Imaging            :     GENERAL RADIOLOGY
      Descendents                :
      Procedure Message          :
```

Report Distribution Lists [RA DISTP]

This option displays data in the Report Distribution Queue file #74.3.

For more information on report distribution, refer to the Index and the chapter on Reports Distribution Edit.

Prompt/**User Response**	Discussion
`Report Distribution Lists`	
`DEVICE: (Printer Name)`	Enter the name of a printer or press the <RET> key to display the output on your screen.

```
Report Distribution Queue List                FEB 10,1997  12:51    PAGE 1
                               CATEGORY OF          INACTIVATION
NAME                           REPORTS              DATE
TOP OF PAGE MESSAGE
--------------------------------------------------------------------------------

CLINIC REPORTS                 OUTPATIENT

***** Clinic Distribution *****
================================================================================
FILE ROOM                      INPATIENT

***** Radiology File Room Distribution *****
================================================================================
MEDICAL RECORDS                ALL REPORTS

***** MAS Medical Records Room Distribution *****
================================================================================
OTHER THAN WARD OR CLINIC      NON WARD OR CLINIC

***** Non Ward or Clinic Reports *****
================================================================================
REQUESTING PHYSICIAN           ALL REPORTS

================================================================================
WARD REPORTS                   INPATIENT

***** Ward Distribution *****
================================================================================
```

Sharing Agreement/Contract List [RA SHARINGP]

This option prints data from the Contract/Sharing Agreement file #34.

For more information on sharing agreements and contracts, refer to the Index and the chapter on Sharing Agreement/Contract Entry/Edit.

Prompt/**User Response**	Discussion
`Sharing Agreement/Contract List`	
`DEVICE: (Printer Name)`	Enter the name of a printer or press the <RET> key to display the output on your screen.

```
Contract/Sharing Agreements                    OCT  3,1996  09:40    PAGE 1
                                TYPE OF    INACTIVATION
AGREEMENT NAME                  AGREEMENT  DATE
------------------------------------------------------------------------------

CONTRACTOR LFL                  CONTRACT
MEMORIAL HOSPITAL               SHARING
UNIVERSITY HOSPITAL             SHARING
```

Standard Reports Print
[RA STANDPRINT]

This option prints data from the Standard Reports file #74.1.

For more information on standard reports, refer to the Index and the chapter on Standard Reports Entry/Edit.

Prompt/**User Response**	Discussion
Standard Reports Print	
DEVICE: (Printer Name)	Enter the name of a printer or press the <RET> key to display the output on your screen. Here is an example of what the report contains:

```
Standard Reports List                          OCT  3,1996  09:40    PAGE 1
REPORT
NUMBER  STANDARD REPORT
------------------------------------------------------------------------------

   1    NORMAL CHEST - PA/LAT
Report Text:
   PA and Lateral views of the chest were obtained.  The bones and soft
   tissues are unremarkable.  The cardiac silhouette is normal in size.  The
   lung fields are clear bilaterally.
Impression:
   Normal Chest X-ray.
```

```
Standard Reports List                          OCT  3,1996  09:40    PAGE 2
REPORT
NUMBER  STANDARD REPORT
------------------------------------------------------------------------------
2    NORMAL LUMBAR SPINE
Report Text:
   The disc spaces are normal.  There is no spondylolysis or
   spondylolisthesis.
Impression:
   Normal lumbar sacral spine.
```

☞Radiopharmaceuticals

Provide a list of radiopharmaceuticals and their synonyms to your Pharmacy ADPAC so that the pharmaceuticals can be added to the Drug file #50 along with their VA Classification of DX200, DX201, or DX202. See an example of Radiopharmaceutical entries with synonyms in the Drug file following this worksheet.

_____

_____ _____ _____ _____

_____

_____ _____ _____ _____

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_____ _____ _____ _____

_____

☞Parent/Descendent Exam and Printsets

DEFINITION

An exam set or printset contains a Parent procedure and its Detailed or Series descendent procedures. Requesting a Parent will automatically cause each descendent to be presented for registration as separate cases under a single visit date and time. If the parent is defined to be a printset, the collection and printing of all common report related data between the descendents is seen as one entity.

COMMON DATA FOR PRINTSETS

For a printset, a single report is entered regardless of how many descendent cases are registered. Common data for all cases in a printset includes all fields recorded in the Rad/Nuc Med Report file #74 and a few fields in the Rad/Nuc Med Patient file #70: report text, impression, diagnostic codes, primary and secondary residents and staff, verifier, pre-verifier, clinical history, verification and pre-verification date/time and physician, transcriptionist, no-purge indicator, reported date, report status, and exam date/time. For printsets, case-related fields that are common data (residents, staff, diagnostic codes, etc.) are now editable only through report editing functions, and are no longer editable via case editing options. This is necessary to insure that there is no opportunity for users to enter different data in these fields for each case in a printset.

NON-COMMON DATA FOR PRINTSETS

Non-common data still exists for each procedure in a printset. Non-common data includes modifiers, case number, exam status, complications, film, and most other fields that can be edited separately for each case.

SINGLE REPORT SETUP FOR PRINTSETS

When setting up Parent type procedures through the Procedure Enter/Edit option, you will see a new prompt, "SINGLE REPORT:", that should be set to YES to indicate that reporting for the registered descendents of the parent procedure will be combined into a single report, making it a printset. If the field is left blank, a separate report will be required for each registered descendent and the cases will NOT be treated as a printset. When descendents are registered in the Rad/Nuc

Med Patient file #70, the "MEMBER OF SET" field on the case record is set automatically by the system as follows:

1 = descendent procedure, separate reports required
2 = descendent procedure, single report for all cases under this exam date/time
blank = not a descendent, separate report required

Selection of any member of a printset in report related functions will bring up certain identifying information (case numbers, procedures) for all cases in the printset.

Report printouts and displays are modified for printsets to show all non-common data (such as procedure names and modifiers) on one report. The report print format for printsets has been changed to include each procedure and its modifiers. Residents, staff, and diagnoses are printed once for each printset because they are the same for cases in the printset. The same changes have been made to screen displays of reports, to email messages containing reports, and to the retained erroneous report that is stored on the report record before amending it.

If a report for a printset is deleted, each exam in the printset will show that its report was deleted.

If a user tries to create a report for a cancelled case, and the cancelled case belongs to a printset where the other cases of the printset already have a report, then the cancelled case will refer to the same report as the rest of the printset if:

the Division parameter allows reports on cancelled cases, or
the user owns the RA MGR security key.

If neither of these conditions is true, the cancelled case will NOT have a report associated with it. If a cancelled case is selected via a voice recognition system, and the case is part of a printset, the user will not be able to enter a report. Instead, an error message will be transmitted notifying him to use VISTA for reporting on this case.

SPECIAL CHARACTER DESIGNATION FOR PRINTSETS

All options that do case lookups and displays will now show special characters to the left of the case number column for cases belonging to a printset**. Note: These will only appear on cases that are entered after the installation of V. 5.0.** This also includes the List Reports in a Batch option and the Distribution Queue Menu options: Clinic Distribution List, Ward Distribution List, and Unprinted Reports List. The Register an Exam and Display Patient Demographics options also display special characters for cases in a printset when the list of the last five procedures is displayed. Options such as Status Tracking do NOT display the

Answer: There are many ways to handle purging. Here are a few of the examples from the sites:

a. We "have the report purge set to coincide with when we purge the film files. That is 5 years."

b.

Activity log cut off	999	days
Report cut off	999	days
Clinical history	999	days
Tracking cut off	999	days
Order data cut off	30	days

c.

Activity log cut-off	90	days
Report cut-off	1825	days
Clinical History	90	days
Tracking time cut-off	90	days
Order data cut-off	30	days

d. "We started full purges of everything over a year old but have now moved to doing it every six months. Do be careful that you have ensured that impressions are supplied. We were getting a lot of 'Refer to report such-and-such' and, of course, it would have been purged too. You will only be able to purge those exams which are Complete, so there may be some clean up to do before you can proceed. If you're really timid, you could archive the global on tape, until you're confident of your procedure."

2. **Question**: What do you do with report text such as "See above" or "Refer to..." when purging?

Answer: One view: "A very important issue was raised. If you plan to purge report text after a period of time, leaving only the impression, make sure that the radiologists know this (and keep reminding them). I have seen many dictation where the impression read something like "As above", which obviously is not that helpful if "the above" has been deleted! In fact, you must specifically warn those who dictate not to do this."

Another view: "We use the Indicate No Purge option when the physician dictates the impression as "see above report". " Note: Transcriptionists need to be trained to do this.

VERIFYING REPORTS

Question: "I would like some input about who can Verify a report. Can it be only the radiologist who dictated and signed the report? Or can a radiologist sign other radiologists' reports?"

Answer: "Radiologists can verify their own reports and, if the site parameters are turned on, a radiologist may also be given the ability to verify other radiologists' reports."

Question: "How can I get the titles of contract radiologists to appear on the report without local modifications?"
Answer: "The Rad/Nuc Med software uses the Signature Block Title field in the New Person file #200 as the title printed to the right of each primary and secondary staff and resident's name. You can edit this field so that it shows that a person classified as Radiology/Nuclear Medicine resident or staff is a contract radiologist."

(See the Troubleshooting chapter for more detail.)

HOLD/CANCELLED/PENDING/SCHEDULED

1. **Question**: Does anyone use the Pending/Hold Rad/Nuc Med Request Log (used to be Log of Pending Radiology Requests)?

   Answer: "We use this list extensively. We also print it to each ward every evening at 8 pm. The nurses love it . They can run down the list and make sure that patients that are to be NPO, are. We haven't had a miss in the last year. We also print to the lab at 5 am each morning. They look for the CTs and Specials and draw these patients early. By the time the patient is ready to be done, the lab work is ready. It has really helped."

2. **Question**: "What do you do in the event the patient is Scheduled. These don't show up on a Pending report. We have so many patients scheduled and the floors "forget" to give the patients preps.

   Answer:
   One site: "There is a option Log of Scheduled Requests by Procedure. We print one for us and each ward prints one daily (Ward/Clinic Scheduled Request Log) to prep the next day's patients. This will group GIs, CTs, BEs, Chests, etc. together and gives the patient name, SSN, procedure, patient